Health Insurance Claim Form

It is important that all relevant sections of the claim form are completed. Failure to provide us with all required information and documentation may delay or prevent the processing and settlement of your claim. You should always attach original receipts to the claim form. We recommend that you retain a copy of all documentation you send to us for your own records, we will be unable to return original documents but would be happy to provide copies on request. The claim form, original receipts and relevant documentation must be sent to us **within 2 months** of the initial treatment date. Any additional documentation sent afterwards must be clearly marked with the policy number, subscriber and patient name and ID number, and the medical condition originally claimed for.

1. Member details

Subscriber details	Title:	Name:	Surname:	
Group name (where applicable):			ID No:	DB: DD/MM/YYYY
Patient details	Title:	Name:	Surname:	
Policy No:			ID No:	DB: DD/MM/YYYY
Tel:		Mobile:	Email:	
Address:				

2. General information

Medical condition you are claiming for:

Date you first became aware of symptoms/medical condition DD/MM/YYYY | Have you previously claimed for this medical condition? Yes ☐ No ☐

Is your claim the result of an accident or work-related illness/injury? Yes ☐ No ☐

Are you covered for medical expenses in part or in full from any other source? Yes ☐ No ☐

If you have answered Yes to any of the above, please give details:

3. Number of documents attached to your claim form

Original receipts:	Test results:	Medical reports:	Hospital case summary/discharge letter:
Blood test results:	Prescriptions:	Other (please specify):	

4. Declaration & Consent

I hereby declare that to the best of my knowledge and belief, the information on this form (including any attached documents) is true and complete, and that the documentation attached is original. I understand and accept that benefits may not be payable if I do not fully disclose any material facts which could influence the assessment and acceptance of my/my dependant's claim by the insurer and that the policy may be invalidated if this claim form is in any way fraudulent. I give explicit and unqualified consent to Citadel Insurance p.l.c. (Citadel) to collect medical information from other insurance companies, doctors and other members of the medical profession, hospitals, clinics, laboratories and other medical facilities who I have consulted about my/my dependant's health, that is necessary and pertaining to my/my dependant's health in order for the validity of the claim to be established. I also hereby authorise any of the above-mentioned service providers to provide Citadel with full medical information concerning myself/my dependant.

Data Protection Notice - Citadel implements strict controls over personal data held in electronic and/or a manual form. Please read this declaration before signing the claim form to understand how your personal data may be processed. I consent to the processing of my personal data by Citadel and its subsidiaries as long as the processing relates to administering my health insurance policy, underwriting, handling and settling of claims, detecting, preventing and suppressing of fraud and the keeping of statistics.

I understand that Citadel may exchange information with others (including but not limited to my insurance intermediary, medical advisers, the Malta Insurance Association or other insurance companies) for the prevention of fraud. I authorise Citadel to keep me informed of its products and services by mail, email or other electronic means, and that I may inform the company in writing if I do not wish to receive this information. I also understand that I have the right to request access to my personal data by contacting Citadel in writing. Citadel is legally bound to follow the provisions of the Data Protection Act, 2001. Citadel is registered with the Office of the Commissioner for Data Protection to process data in accordance with this Act.

Patient's signature
(OR subscriber's signature if patient is under 18 years of age) _____ Date: DD/MM/YYYY

5. Assessment details

Part A - General Practitioner assessment

Patient name:	Type of condition: Acute ☐ Chronic ☐ Acute episode of chronic ☐

Details of symptoms/medical condition:

Date when symptoms would first have been apparent: DD/MM/YYYY	Date of initial consultation: DD/MM/YYYY

Has the patient suffered from this condition in the past? If Yes, please give details:

Does the condition need long term monitoring, consultations, check-ups or tests? If Yes, please give details:

Treatment prescribed, including drugs:

Is the patient currently undergoing any other treatment or taking medication for any other condition? If Yes, please give details:

Signature & official stamp	Email:
	Tel:
	Date: DD/MM/YYYY

Part B - Specialist assessment

All specialist consultations must be referred by your GP. We make an exception for consultations with gynaecologists/paediatricians.

Details of symptoms/medical condition:

Treatment prescribed, including drugs:

Signature & official stamp	Email:
	Tel:
	Date: DD/MM/YYYY

Part C - Details of in-patient / day-patient treatment

You should always contact us before receiving any in-patient or day-patient treatment so we can confirm the extent of cover under your plan and the eligibility of your claim.

Signature & official stamp	Hospital/Clinic:
	Admission date: DD/MM/YYYY
	Discharge date: DD/MM/YYYY

6. Payment Instructions

Payment by cheque will be issued to the subscriber unless the patient is aged 18 and over. Please complete the section below ONLY if payment is to be made to a third party.

Payee name:	ID No:

Payee address:

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